9037 S. Harper Avenue
Chicago, IL 60619
773.734.1386
773.734.1440 (fax)

# REGISTRATION

**STUDENT INFORMATION**

Oldest Student Last Name: ___________________________ Student First Name: ________________________

Gender: _________ Date of Birth: __________________ Race: ______________ Next Year Grade: ________________

Religion: _________________ **Do you receive Child Care Initiative (CCI) or Action for Children? _____ YES ____ NO**

**SIBLING INFORMATION (Only for siblings ATTENDING ST. AILBE)**

_______________________________________________________________________________________________

Sibling's Full Name Gender Date of Birth Next Year Grade

_______________________________________________________________________________________________

Sibling's Full Name Gender Date of Birth Next Year Grade

_______________________________________________________________________________________________

Sibling's Full Name Gender Date of Birth Next Year Grade

**FAMILY INFORMATION**

Student(s) lives with: ______________________ Home phone: (______) _______-__________

Address: ___________________________________________________________________________ __________________

City State Zip Code

**Mother's Information** Title (Ms., Mrs., Mr., Dr.): _________________ Name: ___________________________________

Home: (______) _______-__________ Cell: (______) _______-__________ Work:(______) _______-__________

Email: ______________________________________________________________

Place of employment: ____________________ Occupation: ________________________

**Father's Information** Title (Ms., Mrs., Mr., Dr.): _________________ Name: ___________________________________

Home: (______) _______-__________ Cell: (______) _______-__________ Work:(______) _______-__________

Email: ______________________________________________________________

Place of employment: ____________________ Occupation: ________________________

**What church does your family attend? ______________________________________________________________**

**PHOTO CONSENT**

I give permission to St. Ailbe School, including partners, vendors and affiliates, to use my image/the image of my child(ren) for educational and promotional purposes.

**FINANCIAL AGREEMENT**

I understand that I am responsible for all tuition and fees- including, but not limited to- before and after school care and fundraising all billed through FACTS.

From Most Recent Tax Return: Household Size ________ Adjusted Gross Income ____________________

St. Ailbe
CATHOLIC SCHOOL

9037 S. Harper Avenue
Chicago, IL 60619
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# REGISTRATION

# Medical and Emergency Information Sheet

## MEDICAL INFORMATION

______________________________________________________________________

Student Name Grade Allergies/Medical Conditions

______________________________________________________________________

Student Name Grade Allergies/Medical Conditions

______________________________________________________________________

Student Name Grade Allergies/Medical Conditions

## EMERGENCY CONTACT INFORMATION

#1 Emergency Contact Name: ________________________________________ Relation to Child ______________________

Cell: (______) _______-__________ Home: (______) _______-__________ Work:(______) _______-__________

#2 Emergency Contact Name: ________________________________________ Relation to Child ______________________

Cell: (______) _______-__________ Home: (______) _______-__________ Work:(______) _______-__________

#3 Emergency Contact Name: ________________________________________ Relation to Child ______________________

Cell: (______) _______-__________ Home: (______) _______-__________ Work:(______) _______-__________

Other people who may pick up my child(ren):

1. _____________________________________________________ Relation to child ___________________________

Cell: (______) _______-__________ Home: (______) _______-__________ Work:(______) _______-__________

2. _____________________________________________________ Relation to child ___________________________

Cell: (______) _______-__________ Home: (______) _______-__________ Work:(______) _______-__________

3. _____________________________________________________ Relation to child ___________________________

Cell: (______) _______-__________ Home: (______) _______-__________ Work:(______) _______-__________

## MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgement of the School Principal or his/her designee, there is a necessity for immediate examination and or treatment of my/our child, I/we hereby request and authorize school personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the medical and liability insurance coverage and costs for any diagnosis/treatment and/or for medication deemed necessary for my/our child's medical condition to be disclosed to school personnel and/or medical providers and I/we expressly consent to such disclosure.

**Parent Signature: _______________________________________ Date: _________________**